

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155286		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 09/22/2011	
NAME OF PROVIDER OR SUPPLIER AVALON VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 200 KINGSTON CIR LIGONIER, IN46767			
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/22/11</p> <p>Facility Number: 000184 Provider Number: 155286 AIM Number: 100267210</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Avalon Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully</p>			K0000	<p>Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal law. Please accept our Plan of Correction as our credible allegation of compliance.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K0029 SS=E	sprinklered. The facility has a fire alarm system with smoke detection in the corridor and areas open to the corridors. The facility has a capacity of 67 and had a census of 44 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/23/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:						
	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 storage rooms with combustibles, measuring over 50 square feet in			K0029	1. There were no residents affected by the deficient practice 2. All residents have the potential to be affected by the deficient practice The corridor door to the bulk storage room in the		10/05/2011

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	<p>size, and 1 of 2 water heater rooms were provided with a self closing device. This deficient practice could affect all resident evacuated through the service hall exit and any staff in the break room in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and Maintenance Director on 09/22/11 from 2:15 p.m. to 2:32 p.m., the corridor door to the bulk storage room in the service hall measuring over 50 square feet in size and containing cleaning chemicals, brief, paper towels and cardboard boxes lacked a self closing device. Additionally, the water heater room adjacent to the break room containing fuel fired water heaters lacked a self closing device. This was confirmed by the Maintenance Director at the time of observations.</p> <p>3.1-19(b)</p>				<p>service hall measuring over 50 square feet in size and containing combustibles has been equipped with a self closing device. The water heater room adjacent to the break room was immediately equipped with a self closing device.</p> <p>3. The Maintenance Director was educated on K029; One hour fire rated construction or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self closing and non rated or field applied protective plates that do not exceed 48 inches from the bottom of the door are permitted.</p> <p>4. The Administrator will monitor the self closing devices to ensure that they are working properly and remain in compliance with K029 weekly times 4 weeks then monthly thereafter. Results of the monitoring will be forwarded to the QA committee.</p> <p>5. Completion Date 10/5/2011</p>		

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K0046 SS=F	<p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>1. Based on observation and interview, the facility failed to provide exterior emergency light for 5 of 5 exits. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations with the Administrator, Director of Nursing and the Maintenance Director on 09/22/11 from 1:13 p.m. to 2:40 p.m., exterior light fixtures were observed at all exits and there were no exterior emergency battery operated lights provided. Based on an interview with the Maintenance Director at the time of observation, in the event of a power outage, power would not be provided to these exterior light fixtures until power has been transferred manually to the emergency generator.</p> <p>3.1–19(b)</p>		K0046	<p>1. There were no residents affected by the deficient practice</p> <p>2. All residents have the potential to be affected by the deficient practice The transfer switch to the emergency generator is currently in process of being repaired.</p> <p>3. The Maintenance Director did educate nursing staff on how to manually transfer power to the emergency generator in the event of a power outage</p> <p>4. The Administrator did ensure that staff is educated on how to manually transfer power to the emergency generator The Administrator will also review written records to ensure compliance with 1046 with each load test Results of the monitoring will be forwarded to the QA committee.</p> <p>5. Completion Date 10/22/2011</p> <p>1. There were no residents affected by the deficient practice</p> <p>2. All residents have the potential to be affected by the deficient practice The battery operated emergency task light was tested immediately The battery operated emergency task light was fully operational for the duration of the test</p> <p>3. The Maintenance Director was educated on 1046; Periodic</p>		10/22/2011	

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	<p>2. Based on observation, record review and interview; the facility failed to ensure 1 of 1 emergency light fixtures of at least 1½ hour duration was tested monthly and annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director and the Administrator on 09/22/11 at 2:27 p.m., a battery operated</p>				<p>ttesttng oft emergency lighttng equipmentt requires a ftncttional ttestt shall be conductted on every required battery powered emergency lighttng system at 30 day inttervals ffor a minimum of 30 seconds. An annual ttestt shall be conductted on every required battery powered emergency lighttng systtem ffor nott less tthan 1½ hour duratton. Equipmentt shall be ffully operattional ffor tthe duratton oft tthe testt. Written records shall be keptt by tthe owner ffor inspectton by tthe authoritty having jurisdictton.</p> <p>4. The Administrattor will review tthe documenttatton oft tthe battery operatted emergency task lightt weekly ttimes 4 weeks tthen monthtly tthereafter tto ensure compliance with K046. The resultts oft tthe monittoring will be fforwarded tto tthe QA committee.</p> <p>5. Completton Datte 10/5/2011</p>		

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K0047 SS=F	emergency task light was observed at the emergency generator. Based on an interview with the Maintenance Director during the record review process at 12:41 p.m., there were no written records of a monthly or an annual test regarding the battery operated emergency task light available for review. 3.1-19(b)			K0047			10/22/2011
	Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observation, record review and interview; the facility failed to ensure a continuously illuminated exit sign, where the exit or way to reach the exit was not apparent, was immediately visible for 5 of 5 ways to the exit. LSC 7.10.1.4 requires access to				1. There were no residents affected by the deficient practice 2. All residents have the potential to be affected by the deficient practice The transfer switch to the emergency generator is currently in process of being repaired. The exit lights were tested to ensure that they do illuminate		

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	<p>exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not apparent to the occupants. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations with the Administrator, Director of Nursing and the Maintenance Director on 09/22/11 from 1:13 p.m. to 2:40 p.m., exit signs were illuminated throughout the facility at this time, however, based on an interview with the Maintenance Director at the time of observation, in the event of a power outage, illumination would not be provided to these exit signs until power has been transferred manually to the emergency generator.</p> <p>3.1-19(b)</p>				<p>when the power is manually transferred to the generator</p> <p>3. The Maintenance Director did educate nursing staff on how to manually transfer power to the emergency generator in the event of a power outage</p> <p>4. The Administrator did ensure that staff is educated on how to manually transfer power to the emergency generator. The Administrator will also review written records to ensure compliance with 1047 weekly times 4 weeks then monthly thereafter. Results of the monitoring will be forwarded to the QA committee</p> <p>5. Completion Date 10/22/2011</p>		

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K0066 SS=D	<p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 areas where smoking was permitted was maintained and the metal container with a self closing cover was used for an ashtray. This deficient practice could affect all residents evacuated through the nurses' station exit in the event of any emergency.</p> <p>Findings include:</p> <p>Based on an observation with the</p>			K0066	<p>1. There were no residents affected by the deficient practice</p> <p>2. All residents have the potential to be affected by the deficient practice The smoker's oasis was immediately restored and the cigarette butts were removed from the ground. All other oasis checked and was functioning properly.</p> <p>3. Staff was educated on 066; Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. Metal containers with self closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is</p>		10/05/2011

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K0068 SS=E	<p>Administrator, Director of Nursing and the Maintenance Director on 09/22/11 at 1:18 p.m., the exterior designated smoking area at the nurses' station exit was provided with a "smokers oasis" which is a metal container with a long neck used for cigarette butts. The neck section and the lid had been removed and was laying on the ground. At least fifty cigarette butts were observed on the ground near the smokers oasis and the exit door. Based on an interview with the Administrator at the time of observation, she could not explain why the lid had been removed from the smokers oasis.</p> <p>3.1-19(b)</p>			K0068	<p>permitted.</p> <p>4. The Administrator or designee will visually monitor all exits where smoking is permitted for proper functioning of the smokers oasis weekly times 4 weeks then monthly thereafter. Results of the monitoring will be forwarded to the QA committee.</p> <p>5. Completion Date 10/5/2011</p>		10/05/2011
	<p>Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 boiler rooms containing gas fueled water heaters provided for the exhaust of combustion fumes to the outside. This deficient practice could create an atmosphere rich with exhaust fumes which could cause physical problems for the</p>				<p>1. There were no residents affected by the deficient practice</p> <p>2. All residents have the potential to be affected by the practice. The vent pipe was repaired. Other boiler rooms were checked to ensure compliance with K068.</p> <p>3. The Maintenance Director was educated on K068. The Maintenance Director will add checking the vent pipe for the water</p>		

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K0069 SS=E	staff in the break room. Findings include: Based on observations with the Administrator and the Maintenance Director on 09/22/11 at 2:09 p.m., the water heater room adjacent to the break room had a newly installed water heater. The vent pipe for this water heater was in two sections. The sections did not line up properly and created a gap between the two sections allowing the exhaust fumes to vent into the water heater room. At this time the Maintenance Director attempted to correct the problem but stated the pipe sections had been cut too short by the corporate installers. 3.1-19(b)			K0069	heaters to the preventative maintenance program to ensure compliance with 1068. 4. The Administrator or designee will inspect the vent pipes weekly times 4 weeks then monthly thereafter to ensure compliance. Results will be forwarded to the QA committee. 5. Completion Date 10/5/2011		10/05/2011
	Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to maintain 1 of 1 K Class portable fire extinguishers in the kitchen cooking area in accordance with				1. There were no residents affected by this practice 2. All residents have the potential to be affected by this practice. The placard was placed next to the K Class fire extinguisher identifying its use as secondary		

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	<p>the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect any residents using the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the</p>				<p>source of extinguishment to the kitchen automatic fire suppression system</p> <p>3. Staff was educated on the placard and that NFPA 10, 2-3.2.1 requires a placard be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher.</p> <p>4. The administrator or designee will monitor that the placard is in place weekly times 4 weeks then monthly thereafter. Results of the monitoring will be forwarded to QA committee.</p> <p>5. Completion date 10/5/2011</p>		

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K0144 SS=F	<p>Maintenance Director on 09/22/11 at 2:20 p.m., the kitchen K Class fire extinguisher lacked a placard. Based on an interview with the Maintenance Director at the time of observation, the kitchen K Class fire extinguisher lacked a placard identifying its use as secondary source of extinguishment to the kitchen automatic fire suppression system.</p> <p>3.1-19(b)</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on interview and record review, the facility failed to ensure 1 of 1 emergency generators would provide power to the emergency lighting systems within ten seconds. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.1.1.8 requires the generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. This deficient practice</p>			K0144	<p>1. There were no residents affected by this practice</p> <p>2. All residents have the potential to be affected by this practice. The transfer switch for the emergency generator is in the process of being repaired. The Maintenance Director did educate all shifts on how to manually switch the power to the generator in the event of a power outage</p> <p>3. The Maintenance Director will perform a weekly visual inspection of the generator as well as a monthly load test</p> <p>4. The Administrator will review weekly inspection tests 4 weeks to ensure compliance and then</p>		10/22/2011

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	<p>affects all occupants.</p> <p>Findings include:</p> <p>Based on record review of the generator log titled "Emergency Generator Monthly Test Log" with the Maintenance Director on 09/22/11 at 12:24 p.m., the automatic transfer switch for the emergency generator is no longer functional therefore power must be transferred manually. Based on interview at the time of record review, the Maintenance Director stated a new automatic transfer switch had been purchased and delivery should be in two weeks. He confirmed power would have to be transferred manually and he was the only trained person in the facility who could transfer power.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of the last 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the</p>				<p>monthly thereafter The Administrator will review monthly load tests to ensure compliance and results will be forwarded to the QA committee.</p> <p>5. Completion Date 10/22/2011</p> <p>1. There were no residents affected by this practice</p> <p>2. All residents have the potential to be affected by this practice. Nipsco was notified and a new letter has been obtained to ensure compliance with 14.</p> <p>3. The Maintenance Director was educated to ensure that the off site fuel source for the emergency generator is from a reliable source and documentation is reviewed annually.</p> <p>4. The Administrator will review each annual letter to ensure compliance with 14</p> <p>5. Completion Date 10/5/2011</p>		

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	<p>emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, whichever is greater, at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the "Emergency Generator Monthly Test Log" with the Maintenance Director on 09/22/11 at 12:34 p.m., no documentation was available to show a generator load test was completed in April 2011. Based on an interview with the Maintenance Director at the time</p>						

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	<p>of record review, no other documentation was available for review.</p> <p>3.1-19(b)</p> <p>3. Based on record review and interview, the facility failed to provide the complete documentation for the weekly visual inspection of 1 of 1 emergency generators providing power to the emergency systems. NFPA 99, 3-5.4.2 requires a written record or inspection, performance, exercise period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 99, 3-4.1.1(b)1 requires generating testing be in accordance with NFPA 110, Standard for Emergency and Standby power Systems, Chapter 6. NFPA 110, 6-4.1 requires Level 1 and Level 2 EPSS including all appurtenant components shall be inspected weekly. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a review of the generator</p>						

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	<p>log "Emergency Generator Weekly Inspection Checklist" with the Administrator and the Maintenance Director on 09/22/11 at 12:23 p.m., documentation of a weekly inspection between 03/09/11 and 05/25/11 was not available for review. Based on an interview with the Administrator at the time of record review, the facility was without a Maintenance Director at that time and a person from the corporate office did the weekly inspections. Currently, she had no documentation available to confirm this statement.</p> <p>3.1-19(b)</p> <p>4. Based on interview and record review, the facility failed to ensure the off site fuel source for 1 of 1 emergency generators was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1 Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS):</p>						

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	a) Liquid petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability.						

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	<p>3. A statement that there is a low probability of interruption of the natural gas.</p> <p>4. A brief description that supports the statement regarding the low probability of interruption,</p> <p>5. The signature of a technical person from the natural gas provider.</p> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview with the Maintenance Director on 09/22/11 at 2:40 p.m., the fuel source for the emergency generator was natural gas. Based on record review, the facility did have a letter from their natural gas provider (NIPSCO) dated December 7, 2009 but the letter did not include all the items above required for a letter confirming the reliability of a natural gas fuel source for an emergency generator. The letter lacked supporting statements of reliability of natural gas, low probability of interruption of the natural gas service and a signature of a technical person. The</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

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	Administrator spoke with NIPSCO and was told a new letter would be mailed to the facility. 3.1-19(b)						